

CSOF MEDICAL MONOGRAPHS

**DEPRESSION IN THE PRIMARY CARE SETTING:
CLINICAL NOTE**

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13. ABSTRACT (Maximum 200 words) Background: The diagnosis of depression is associated with a high degree of morbidity, mortality, and economic cost. Thus, depression needs to be accurately diagnosed and documented by primary health care providers in the managed care environment. Methods: The Family Medicine Center, an ambulatory care residency clinic, undertook a continuous quality improvement (CQI) review project to assess its effectiveness in diagnosing depression. Reviewers accomplished a critical review of charting looking for accuracy in diagnoses of depression according to published DSM-IV criteria. Interventions were established. A second and third review were accomplished to assess diagnostic improvement. Results: Of 2800 active patients, 51 patients were diagnosed as depressed. Thirteen of 51 met major depression criteria or had mental health care provider support for the diagnosis. Interventions resulted in 60 additional depression diagnoses. Sixteen of these 60 met DSM-IV criteria for major depression. Conclusions: As a probable standard model for the diagnosis of depression by primary health care providers, the Family Medicine Center benefited significantly from this CQI audit of diagnostic effectiveness. Deficits were clearly identified with interventions in diagnosis and documentation producing better results. The study suggests the need for even greater interventional strategies.				
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DEPRESSION IN THE PRIMARY CARE SETTING: CLINICAL NOTE

ABSTRACT

Background: The diagnosis of depression is associated with a high degree of morbidity, mortality, and economic cost. Thus, depression needs to be accurately diagnosed and documented by primary health care providers in the managed care environment.

Methods: The Family Medicine Center, an ambulatory care residency clinic, undertook a continuous quality improvement (CQI) review project to assess its effectiveness in diagnosing depression. Reviewers accomplished a critical review of charting looking for accuracy in diagnoses of depression according to published DSM-IV criteria. Interventions were established. A second and third review were accomplished to assess diagnostic improvement.

Results: Of 2800 active patients, 51 patients were diagnosed as depressed. Thirteen of 51 met major depression criteria or had mental health care provider support for the diagnosis. Interventions resulted in 60 additional depression diagnoses. Sixteen of these 60 met DSM-IV criteria for major depression.

Conclusions: As a probable standard model for the diagnosis of depression by primary health care providers, the Family Medicine Center benefited significantly from this CQI audit of diagnostic effectiveness. Deficits were clearly identified with interventions in diagnosis and documentation producing better results. The study suggests the need for even greater interventional strategies.

INTRODUCTION:

As many as 41% of patients seen in the primary care setting exhibit some form of depression, either primary or secondary. It should be noted that more patients are seen in the primary care setting for treatment of depression than in the mental health care sector. (1,2) With that in mind, it also should be noted that one-third to one-half of primary care patients with major depression are either inaccurately diagnosed or go untreated. (1,2)

The Family Medicine Center is an ambulatory care family practice residency clinic located in Colorado Springs. A continuous quality improvement (CQI) project was undertaken to assess the clinic's effectiveness at diagnosing depression. The project was initially designed to: 1) identify the accuracy of documenting depression according to the DSM-IV criteria -- this was accomplished by an initial chart review; 2) establish an interventional program to improve the accuracy of documentation; and, 3) make recommendations on overall management of patients with depression. The ultimate goal of the CQI project was to test a model for improving clinic standards in the diagnosis, treatment, and management of depression.

METHODS:

When patients are seen at the Family Medicine Center, all diagnostic codes assigned for any given visit are entered into a computer database. This existing database was used to generate a report of all active patients diagnosed with major depression.

Three chart reviews were performed. The initial review was done in November 1994. This included all active patients diagnosed with depression through that month. The second review consisted of all patients newly diagnosed with depression from December 1994 through May 1995. The third review consisted of all patients newly diagnosed with depression from June 1995

through January 1996. The second and third reviews were done after interventions were made on the basis of findings from the initial chart review. Interventions included placing the diagnostic criteria for depression taken from the DSM-IV and a Zung Self-Reporting Depression Scale in the database for access by resident physicians during patient encounters.

All charts were reviewed by two physicians using the diagnostic criteria for depression taken from the DSM-IV and then tabulated (Figure 1). Supporting documents from mental health care providers also were reviewed and noted. Additionally noted was the presence of an initial self-rating depression scale.

RESULTS:

There are approximately 2800 active patient files at the Family Medicine Center. In the initial chart review, 51 active patients with a diagnosis of depression were identified. Thirteen out of 51 charts either met the criteria for Major Depression or contained a report from a mental health care provider supporting that diagnosis (Table 1). Most charts had three or four criteria documented. Few charts had depression scales of the patients' subjective review of their own symptoms. Some of the charts had the diagnosis of depression accompanying an organic disease process such as alcohol and/or drug abuse or head injuries.

Following implementation of the interventions mentioned under **Methods**, in the second chart review, 34 patients were identified who had been newly diagnosed with depression. Ten out of 34 patients met the criteria for depression per the DSM-IV criteria (Table 1). In addition to the foregoing, another 12 patients had only a Zung Self-Reporting Depression Scale on their charts.

In the third review, a total of 26 patients were newly diagnosed with depression. Six of the 26 patients met the criteria for depression per DSM-IV.

DISCUSSION:

Accurately diagnosing depression requires the presence of at least five symptoms during a two week period as stated in the DSM-IV. (3) Proper documentation is required for those criteria. Documentation of symptoms becomes critical because with implementation of specific treatment interventions, the patient is then followed for depression assessing any change (hopefully improvement) against those specific criteria.

Another crucial part of tracking patient improvement is use of a self-reporting system of patient symptoms. The Zung Self-Reporting Scale and the Beck Depression Inventory are two such indices. (4)

Self-reporting scales should not be used to directly diagnose depression. These scales are designed to be used either as a screening tool for depression or as a tracking tool for measuring improvement after specific therapies. (5)

The initial chart review identified deficits in the three areas that were to be observed in the CQI project. The deficits were: 1) inaccurate documentation of the criteria for depression based on the DSM-IV criteria; 2) lack of supporting documents from mental health providers; and, 3) lack of either documented subjective symptoms (patient-reported) or a self-reporting depression scale to track improvement of patient symptoms and thus chart success of treatment.

An intervention initiated at the Family Medicine Center helped correct these deficits. The criteria taken from the DSM-IV for diagnosing major depression was entered into the database for all care givers to use in patient evaluation. In addition, a Zung Self-Reporting Depression Scale was likewise entered so that it could be accessed and administered to the patient during an initial encounter for screening for possible depression and for follow-up evaluation.

The second chart review revealed some improvement in accuracy of documentation. An improvement also was noted in increased use of the Zung Self-Reporting Depression Scale. However, the review revealed that the scale was mistakenly being used to diagnose depression. The results of the third chart review reflected those of the second.

Another discrepancy was incidentally noted. The expected percentage of patients in the primary care setting with depression was 41% based on published figures. (1,2) Yet, only three percent of the patients at the Family Medicine Center were diagnosed with depression. This is an interesting anomaly. It is the authors' opinion that the Family Medicine Center is above the standard for primary care providers in diagnosing depression because depression is constantly being addressed in psychiatric case conferences attended by all family practice residents and faculty.

Depression is a debilitating illness with a high degree of morbidity, mortality, and economic cost. With the increase in managed health care, it is more probable than ever that patients suffering with depression will be seen by primary health care providers. Better diagnosis and treatment will be needed to reduce this high cost to society. Recommendations would include requiring a high index of suspicion for diagnosis of depression, for the use of screening tools such as *PRIME-MD*, and/or a self-reporting depression scale in all patients suspected of having depression. (1, 5) Screening all new patients with these tools should be seriously considered.

The health care provider should adhere to proper diagnostic criteria for depression and learn to elicit confirming data from the patient. Secondly, an initial self-report of symptoms by the patient should be obtained and charted. This will allow for tracking and evaluation of treatment plans. This can be achieved by the use of a special depression note (Figure 2) and/or use of a self-reporting depression scale.

This paper is not meant to address the total management and treatment of the depressed patient. Before such management and treatment can occur, primary health care providers need to identify patients with depression, accurately diagnose and document the criteria for depression, and obtain better supporting documentation from mental health care providers.

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Table 1 Results of Chart Reviews

	<u>First Review</u>	<u>Second Review</u>	<u>Third Review</u>	<u>Total patients from all reviews</u>	<u>% of active patients</u>
#patients diagnosed with depression	51	34	26	111	3%
#patients with correct documentation	13(25%)	10(29%)	6(23%)	29	<1%

Figure 1.

DIAGNOSIS OF DEPRESSION

TRACKING				DIAGNOSTIC CRITERIA
#	PATIENT	CRITERIA MET YES NO		DIAGNOSTIC CRITERIA FOR DEPRESSION TAKEN FROM DSM IV
1.				MAJOR DEPRESSIVE EPISODE A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations. (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood. (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains. (4) insomnia or hypersomnia nearly every day (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (6) fatigue or loss of energy nearly every day (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide B. The symptoms do not meet criteria for a Mixed Episode (see p. 165, Diagnostic Criteria from DSM-IV) C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism). E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
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Figure 2

FOLLOW UP DEPRESSION NOTE

weight , height, temp	FEAR___ Depressed mood___ agitation___	MEDS
BP	Worry___ loss of interest/pleasure in activities___	
Physical Exam	Agitation___ Insomnia___ Weight Changes___	ALLS.
	Fatigue___ Hypersomnia___ worthlessness___	
	Difficulty concentrating___ helplessness___	FMHxPsy
	Recurrent thoughts of death___ hopelessness___	
	Loss of energy___ Psychomotor retardation___	CurMedHx

Side Effects/Sexual Dysfunction?

Chem. Dep.?	Counseling Y N _____	LABS:
Sex Abuse?		CBC
Physical Abuse?		SMAC
Spousal Abuse?		TFT
		ECG >40
		Drug Levels

Assessment

Plan
